Department of Health and Human Services

Nevada Academy of Health

Jim Gibbons, Governor

Michael J. Willden, Director

02.27.09

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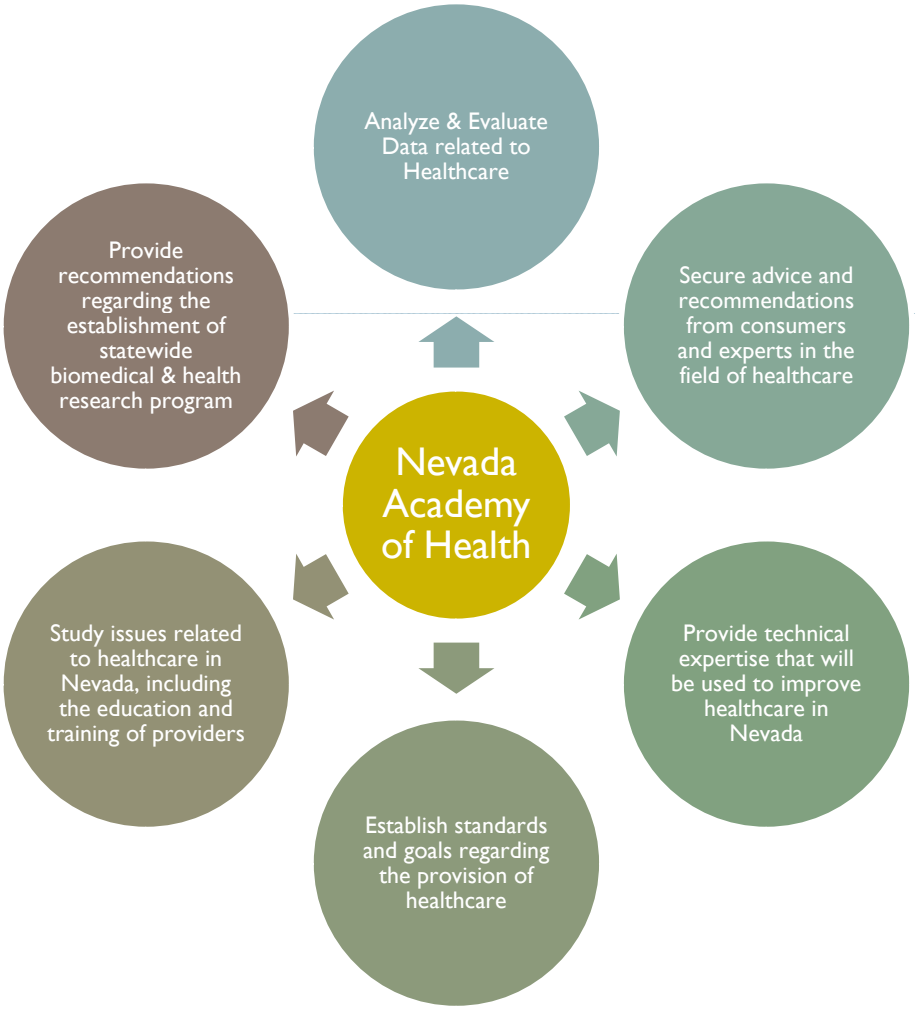
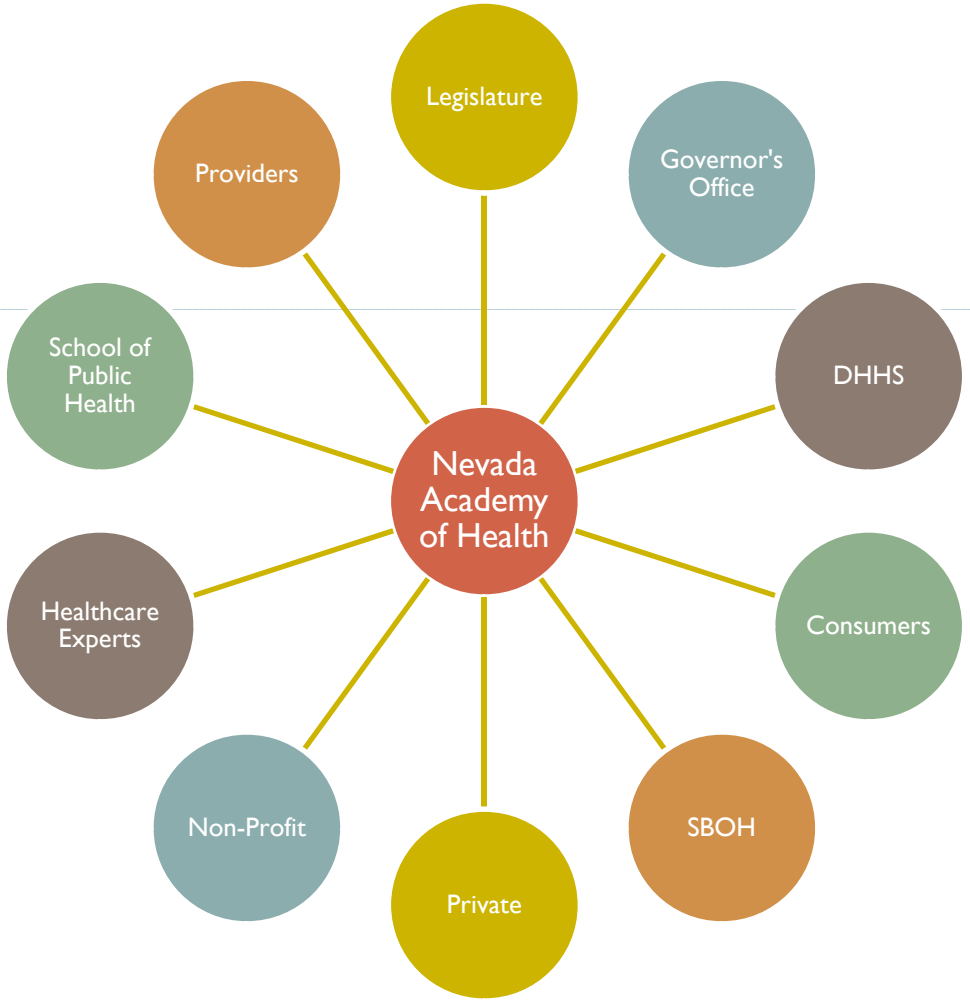
Academy Roles & Responsibilities



Academy System Partners



Academy System Process

1. • Nevada Academy of Health secures data and advice from various healthcare experts and consumers.

2. • Nevada Academy of Health analyzes and evaluates the healthcare data.

3. • Nevada Academy of Health provides ongoing healthcare policy recommendations to the Governor's Office and the Legislature.

Governor's Commission on Healthcare

Professional Education, Research and Training October 2006 Report

- Recommended Establishing a Nevada Academy of Health
  - The Nevada Governor's Commission on Healthcare recommends creating a not-for-profit, statewide, organization composed of representatives from Nevada's health research, education, and training institutions. Policymakers need objective and targeted recommendations developed through a systematic process by which they may evaluate these proposals for clinical, educational, and scientific integrity; priorities; quality; correlation with Nevada's population health needs; and resource use effectiveness. The core mission of this organization would be to provide ongoing policy recommendations to the Governor's office and the Legislature relative to the State's needs and priorities regarding public and private healthcare professional education, medical research, and conducting strategic planning for improved healthcare outcomes based upon Nevada's identified needs.

Senate Bill 171

- The Nevada Academy of Health, created during the 2008 legislative session by Senate Bill 171, is tasked with performing duties as assigned by SB 171, which include:
  - Studying issues related to health care in Nevada, including the education and training of providers.
  - Establishing standards and goals concerning the provision of health care.
  - Analyzing and evaluating data related to health care.
  - Providing recommendations concerning the establishment of a statewide biomedical and health research program.
- The Nevada Academy of Health will also provide assistance and technical expertise that will be used to improve health care in Nevada, and secure advice and recommendations from consumers, as well as experts in the field of health care.

Senate Bill No. 171–Senators Heck, Townsend, Washington, Nolan, Hardy, Beers, Cegavske, Raggio and Rhoads

Joint Sponsors: Assemblymen Gansert, Hardy, Marvel, Beers, Horne, Mabey, Manendo, Settelmeyer and Stewart

CHAPTER.....

AN ACT relating to health; creating the Nevada Academy of Health; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

This bill creates the Nevada Academy of Health and authorizes the Legislative Committee on Health Care, which is established pursuant to NRS 439B.200, to prescribe certain duties and make various requests of the Academy. This bill expires by limitation on June 30, 2009.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 439B of NRS is hereby amended by adding thereto a new section to read as follows:

1. There is hereby established the Nevada Academy of Health consisting of 14 members as follows:

(a) The Director or his designee;

(b) One member who represents the Nevada System of Higher Education appointed by the Board of Regents of the University of Nevada;

(c) Six members appointed by the Governor;

(d) Two members appointed by the Majority Leader of the Senate;

(e) Two members appointed by the Speaker of the Assembly;

(f) One member appointed by the Minority Leader of the Senate; and

(g) One member appointed by the Minority Leader of the Assembly.

2. The members appointed to the Academy pursuant to subsection 1 must not be legislators and, to the extent practicable, must:

(a) Represent agencies and organizations that provide education or training for providers of health care;

(b) Be advocates for the rights of patients;

(c) Be recognized academic scholars; or

(d) Be members of the general public who have specialized knowledge and experience that are beneficial to the Academy.

3. The Chairman of the Academy must be elected from among the members of the Academy.

4. Each member of the Academy who is not an officer or employee of the State serves without compensation and is not entitled to receive a per diem allowance or travel expenses.

5. Each member of the Academy who is an officer or employee of the State must be relieved from his duties without loss of his regular compensation so that he may attend meetings of the Committee or the Academy and is entitled to receive the per diem allowance and travel expenses provided for state officers and employees generally, which must be paid by the state agency that employs him.

6. A vacancy occurring in the membership of the Academy must be filled in the same manner as the original appointment. A member of the Academy may be reappointed.

7. The Academy shall:

(a) Perform any duties prescribed by, and comply with all requests from, the Committee;

(b) Study issues relating to health care in this State, including, without limitation, medical and clinical research and the education and training of providers of health care;

(c) Establish standards and goals concerning the provision of health care which are measurable and regularly evaluated;

(d) Analyze and evaluate data relating to health care that is created, collected or reviewed by the Committee and the Department;

(e) Promote cooperation between the public and private sectors, including the transfer of technology used to provide health care and the establishment of business partnerships that promote economic development in this State;

(f) Provide recommendations to the Governor and the Legislature concerning the establishment of a statewide biomedical and health research program;

(g) Provide to the Committee:

(1) Such assistance and technical expertise on matters relating to health care as the Committee may request; and

(2) Advice and recommendations from consumers of health care; and

(h) Provide to the Department, at the direction of the Committee:

(1) Technical expertise in matters relating to health care; and

(2) Advice and recommendations from consumers of health care.

8. The Academy may appoint advisory committees if necessary or appropriate to assist the Academy in carrying out the provisions of this section.

9. The Academy may accept gifts, grants and donations of money from any source to carry out the provisions of this section.

Sec. 2. NRS 439B.220 is hereby amended to read as follows:

439B.220 The Committee may:

1. Review and evaluate the quality and effectiveness of programs for the prevention of illness.

2. Review and compare the costs of medical care among communities in Nevada with similar communities in other states.

3. Analyze the overall system of medical care in the State to determine ways to coordinate the providing of services to all members of society, avoid the duplication of services and achieve the most efficient use of all available resources.

4. Examine the business of providing insurance, including the development of cooperation with health maintenance organizations and organizations which restrict the performance of medical services to certain physicians and hospitals, and procedures to contain the costs of these services.

5. Examine hospitals to:

(a) Increase cooperation among hospitals;

(b) Increase the use of regional medical centers; and

(c) Encourage hospitals to use medical procedures which do not require the patient to be admitted to the hospital and to use the resulting extra space in alternative ways.

6. Examine medical malpractice.

7. Examine the system of education to coordinate:

(a) Programs in health education, including those for the prevention of illness and those which teach the best use of available medical services; and

(b) The education of those who provide medical care.

8. Review competitive mechanisms to aid in the reduction of the costs of medical care.

9. Examine the problem of providing and paying for medical care for indigent and medically indigent persons, including medical care provided by physicians.

10. Examine the effectiveness of any legislation enacted to accomplish the purpose of restraining the costs of health care while ensuring the quality of services, and its effect on the subjects listed in subsections 1 to 9, inclusive.

11. Determine whether regulation by the State will be necessary in the future by examining hospitals for evidence of:

(a) Degradation or discontinuation of services previously offered, including without limitation, neonatal care, pulmonary services and pathology services; or

(b) A change in the policy of the hospital concerning contracts,

➥ as a result of any legislation enacted to accomplish the purpose of restraining the costs of health care while ensuring the quality of services.

12. Study the effect of the acuity of the care provided by a hospital upon the revenues of the hospital and upon limitations upon that revenue.

13. Review the actions of the Director in administering the provisions of this chapter and adopting regulations pursuant to those provisions. The Director shall report to the Committee concerning any regulations proposed or adopted pursuant to this chapter.

14. Identify and evaluate, with the assistance of an advisory group, the alternatives to institutionalization for providing long-term care, including, without limitation:

(a) An analysis of the costs of the alternatives to institutionalization and the costs of institutionalization for persons receiving long-term care in this State;

(b) A determination of the effects of the various methods of providing long-term care services on the quality of life of persons receiving those services in this State;

(c) A determination of the personnel required for each method of providing long-term care services in this State; and

(d) A determination of the methods for funding the long-term care services provided to all persons who are receiving or who are eligible to receive those services in this State.

15. Evaluate, with the assistance of an advisory group, the feasibility of obtaining a waiver from the Federal Government to integrate and coordinate acute care services provided through Medicare and long-term care services provided through Medicaid in this State.

16. Evaluate, with the assistance of an advisory group, the feasibility of obtaining a waiver from the Federal Government to eliminate the requirement that elderly persons in this State impoverish themselves as a condition of receiving assistance for long-term care.

17. Conduct investigations and hold hearings in connection with its review and analysis.

18. Apply for any available grants and accept any gifts, grants or donations to aid the Committee in carrying out its duties pursuant to this chapter.

19. Direct the Legislative Counsel Bureau to assist in its research, investigations, review and analysis.

20. Recommend to the Legislature as a result of its review any appropriate legislation.

21. Prescribe duties and make requests, in addition to those set forth in section 1 of this act, of the Nevada Academy of Health established pursuant to that section.

Sec. 3. 1. The members of the Nevada Academy of Health must be appointed to terms that end on June 30, 2009.

2. It is the intent of the members of the 74th Session of the Legislature that if the expiration of this act on June 30, 2009, does not occur because of subsequent revisions by the 75th Session of the Legislature, that the terms of the members of the Nevada Academy of Health be established as 3-year terms.

Sec. 4. This act becomes effective on July 1, 2007, and expires by limitation on June 30, 2009.

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Academy Membership List

- Appointed by Statute
  - Mike Willden, Director, Department of Health and Human Services
  - Mike Uboldi, President, St. Mary's Regional Medical Center (Senate Majority Leader)
  - Dr. Linda Ash-Jackson, Medical Director, Hometown Health/Care Coordinator at Renown Medical (Senate Majority Leader)
  - Bobbette Bond, Executive Director, Nevada Health Care Policy Group (Assembly Speaker)
  - Dr. John Ellerton, Chief of Staff, University Medical Center (Assembly Speaker)
  - Dr. Mary Guinan, State Health Officer & Dean, UNLV School of Public Health (Senate Minority Leader)
  - Dr. Weldon Havins Jr., President, Clark County Medical Society (Assembly Minority Leader)
  - Dr. Maurizio Trevisan, Vice Chancellor & CEO of the University of Nevada Health Sciences System (Board of Regents)
- Appointed by Governor
  - Kathleen Conaboy, Government Affairs Director, McDonald, Carano, Wilson
  - Elena Lopez-Bowlan, APN
  - Dr. Michael Rodolico, Executive Director, HAWC (Vice-Chair)
  - Bill Welch, Executive Director, Nevada Hospital Association
  - Cynthia Kiser Murphey, President & COO, New York, New York (Chair)
  - Dr. Ole Thienhaus, Dean University of Nevada School of Medicine

Nevada Health Scorecard Highlights

- WORST INDICATORS
  - State health expenditure (% of GSP) 48th
  - Primary care physicians (per 100,000 population) 46th
  - Registered nurses (per 100,000 population) 50th
  - Children uninsured 49th
  - Children with a medical home 50th
  - Children immunized 50th
  - Infectious disease rate 33rd
  - Adults who visited a doctor in past 2 years 47th
  - Adults with poor mental health 51st
  - Violent crime rate 48th

Nevada Health Scorecard Highlights

- AREAS OF BETTER OR AVERAGE STANDING
  - Median annual household income — 16th
  - Poverty rate — 18th
  - Children who have ever breastfed — 13th
  - Adults who are overweight — 16th
  - Estimated rate of new cancer cases — 12th
  - Cancer death rate — 18th
  - Preventable hospitalization rate — 13th
  - Motorists using safety belts — 3rd

Nevada Academy of Health

NEVADA HEALTH SCORECARD

January 14, 2009

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KEY

ACGME	Accreditation Council for Graduate Medical Education
CQP	Congressional Quarterly Press
CWF	The Commonwealth Fund
KFF	Kaiser Family Foundation
SND	State of Nevada Demographer
UHF	United Health Foundation
n^{th}	rank
Δ	change relative to prior report
B	gotten better
W	gotten worse
N	no change
↑	increase
↓	decrease
☆	state capitol
★	county seat

INTRODUCTION

The Nevada Health Scorecard is a compilation of health indicators, or 'scores', and ranks drawn from the following state health ranking sources:

- Congressional Quarterly Press
- The Commonwealth Fund
- Kaiser Family Foundation
- United Health Foundation

These publications were included because of their reputation as credible and because they rank each state based on its underlying score for each health indicator. Although there is virtually an endless pool of indicators to choose from, those selected by each health ranking source as core were included in this scorecard. For instances where an indicator had been calculated by more than one source, whichever provided the most current figure—all else equal—was represented on the scorecard. Moreover, as statewide indicators, it is important to bear in mind that they only reflect an aggregate view of the states, not the reality as it is in each county, city, or municipality. There can be and is great variability at the county and city level.

The rank order of the scorecard has been adapted from the many sources to be consistent, with 1st indicating a best ranking and either 50th or 51st a worst ranking. Only The Commonwealth Fund and Kaiser Family Foundation included the District of Columbia, so a rank of 51st is possible for these sources. However, since a number of indicators in the Health Care Finance & Expenditure section could not be assigned a best or worst ranking due to the nature of the indicator, they were instead listed from most, 1, to least, 50 or 51, to show Nevada's position relative to the other states.

Finally, to show how Nevada may have changed over time for any particular indicator, columns for change in both rank and score have been included when the figures necessary to establish this were available. This information is to be interpreted as change relative to a prior report, with the year of the prior report noted below and the possible responses being gotten better, worse, or not having changed at all. These responses are also color-coded for ease of viewing, with gotten better in green, gotten worse in red, and not having changed in yellow. For the Health Care Finance & Expenditure section, arrows denote whether the figure has increased or decreased relative to a prior report.

Hyperlinks have been included in the electronic version of this document for indicators provided by The Commonwealth Fund, Kaiser Family Foundation, and United Health Foundation. When additional information broken down by race/ethnicity is available, the note [r/e] follows its respective indicator. To access any of these links, simply hold the CTRL key and click on either the title of the desired indicator or the race/ethnicity notation.

HEALTH CARE FINANCE & EXPENDITURE

	RANK		SCORE		STATE			
	n^{th}	Δ	value	Δ	best		worst	
median annual household income								
KFF	16th 2007	W 2002	$53,008 2007	B 2002	NJ	$65,933	MS	$35,971
poverty rate (based on household income) [r/e]								
KFF	18th 2005	-	10.6% 2005	-	NH	5.6%	DC	21.3%
children[a] in poverty								
UHF	19th 2007	W 2003	14.1% 2007	W 2003	NH	6.5%	MS	32.8%
population uninsured								
UHF	43rd 2007	B 2003	18.4% 2007	W 2003	MA	7.9%	TX	24.9
children uninsured								
KFF	49th 2007	B 2002	16.8% 2007	B 2002	MA	5.1%	TX	21.8%
private sector firms offering health insurance								
KFF	18th 2006	B 2001	56.7% 2006	N 2001	HI	89.6%	MT	40.1%
adults always able to afford to see a doctor in the past year								
CWF	36th 2004	-	85.3% 2004	-	HI	96.6%	MS	80.1%
public health funding (per capita)								
UHF	48th 2006	N 2005	$36 2006	B 2005	HI	$198	IN	$33

HEALTH CARE FINANCE & EXPENDITURE

	RANK		SCORE		STATE			
	*n*th	Δ	value	Δ	most		least	
health care expenditure (per capita)								
KFF	46 2004	= 2000	$4,569 2004	↑ 2000	**DC**	$8,295	**UT**	$3,972
state health expenditure (millions)								
KFF	39 2003	↑ 2001	$1,649 2003	↑ 2001	**NY**	$44,564	**WY**	$709
state health expenditure (of GSP)								
KFF	48 2003	↑ 2000	1.9% 2003	↑ 2000	**MS**	5.9%	**CO/VA**	1.8%
state Medicaid expenditure (millions)								
KFF	39[b] 2006	↓ 2003	$1,163 2006	↑ 2003	**CA**	$31,174	**WY**	$409
Medicaid payments (per enrollee)								
KFF	34 2005	↓ 2000	$4,462 2005	↑ 2000	**DC**	$7,941	**CA**	$2,701
Medicare reimbursements (per enrollee)								
CWF	42 2003	-	$7,109 2003	-	**NJ**	$8,076	**HI**	$4,530
adults[c] enrolled in Medicaid [r/e]								
KFF	50 2007	= 2002	3.6% 2007	↑ 2002	**DC**	15.4%	**NH**	3.1%
children enrolled in Medicaid [r/e]								
KFF	51 2007	↓ 2002	14.5% 2007	↑ 2002	**DC**	44.0%	**NV**	
average annual family health insurance premium								
CQP	25 2004	↑ 2003	$9,970 2004	↑ 2003	**NJ**	$11,425	**ND**	$7,800
health insurance premium per private employee								
CWF	9 2004	-	$3,874 2004	-	**AK**	$4,379	**UT**	$3,034
average family health insurance premium paid by employee								
KFF	41 2006	↑ 2001	22% 2006	↑ 2001	**FL**	33%	**WY**	19%
average personal health insurance premium paid by employee								
KFF	45 2006	= 2001	15% 2006	= 2001	**VA**	24%	**HI**	15%

HEALTH CARE WORKFORCE

	RANK		SCORE		STATE			
	*n*th	Δ	value	Δ	best		worst	
primary care physicians (per 100,000) [r/e]								
UHF	46th 2006	N 2007	85.3 2006	W 2007	MD	178.6	ID	78.9
projected physician assistants (per 100,000)								
KFF	38th 2008	-	18 2008	-	AK	53	MS	3
registered nurses (per 100,000)								
KFF	50th 2007	B 2002	572 2007	W 2002	DC	1,379	AZ	546
dentists (per 100,000)								
CQP	47th 2004	B 2000	43 2004	B 2000	HI	83	MS	40
medical school graduates								
KFF	43rdd 2007	W 2005	53 2007	N 2005	NY	1,633	SD	48
pediatricians (per 100,000)								
CQP	43rd 2005	W 2001	56 2005	B 2001	MA	184	ID	34
psychiatrists (per 100,000)								
CQP	46th 2005	B 2001	7 2005	B 2001	MA	34	ID	6
pharmacists (per 100,000)								
CQP	28th 2005	N 2004	79 2005	B 2004	NE	103	AK	54
paramedics (per 100,000)								
CQP	46th 2005	N 2004	37 2005	N 2004	WI	129	NE	27
rate of residents in core and specialty programs (per 100,000)								
ACGME	46th 2008	-	12.0 2008	-	DC	321.8	MT	2.1
rate of residents completing all accredited training (per 100,000)								
ACGME	47th 2008	-	2.7 2008	-	DC	94.1	MT	0.9

HEALTH CARE ACCESS & CAPACITY

	RANK		SCORE		STATE			
	*n*th	Δ	value	Δ	best		worst	
community hospital beds [e] (per 100,000)								
CQP	45th 2005	B 2001	194 2005	W 2001	SD	558	WA	171
persons lacking access to primary care								
CQP	38th 2006	W 2002	14.8% 2006	W 2002	NJ	2.2%	LA	35.7%
geographic disparity[f] **of health outcomes** (as a differential percentage)								
UHF	46th 2005	W 2007	17.6% 2005	W 2007	DE	4.2%	SD	26.5%
adults with a usual source of care[g]								
CWF	51st 2004	-	66.3% 2004	-	DE	89.4%	NV	
children with a medical home[h]								
CWF	50th 2003	-	34.5% 2003	-	NH	61.0%	MS	33.8%
adults who visited a doctor in the past two years								
CWF	47th 2000	-	77v% 2000	-	DC	91.5%	WY	73.9%
adults who visited a dental clinic in the past year								
KFF	40th 2006	B 1999	66.2% 2006	B 1999	CT	80.5%	OK	58.0%
adults[i] **who received screening and preventive care**								
CWF	47th 2004	-	34.3% 2004	-	MN	50.1%	ID	32.6%
children who received medical and dental preventive care								
CWF	50th 2003	-	46.8% 2003	-	MA	74.9%	ID	45.7%
children[j] **who received mental care for an emotional, behavioral, or developmental issue**								
CWF	45th 2003	-	53.2% 2003	-	WY	77.2%	TX	43.4%

HEALTH CARE QUALITY

	RANK		SCORE		STATE			
	n^{th}	Δ	value	Δ	best		worst	
mortality rate of cases amenable[k] to health care (per 100,000)								
CWF	38th 2002	-	111.5 2002	-	MN	70.2	DC	160.0
preventable hospitalization rate (per 1,000 Medicare enrollees)								
UHF	13th 2005	W 2003	65.3 2005	W 2003	HI	32.2	WV	114.4
Medicare patients who gave a best rating for health care received in past year								
CWF	45th 2003	-	65.9% 2003	-	MT	74.4%	NM	61.2%
Medicare hospital admission for ambulatory sensitive conditions[l]								
CWF	9th 2003	-	5,594 2003	-	HI	4,069	MS	11,537
Medicare readmissions after 30 days (of admissions)								
CWF	50th 2003	-	23.5% 2003	-	VT	13.2%	LA	23.8%
home health patients admitted to a hospital								
CWF	15th 2004	-	24.6% 2004	-	UT	18.3%	LA	46.4%
hospital patients who received recommended care for acute myocardial infarction, congestive heart failure, or pneumonia								
CWF	45th 2004	-	79.8% 2004	-	RI	88.4%	NM	79.0%
heart failure patients whose health care provider listens, explains, shows respect, and spends enough time with them								
CWF	46th 2003	-	66.0% 2003	-	VT	74.9%	AZ	63.1%
heart failure patients given written instructions at discharge								
CWF	50th 2005	-	22% 2005	-	NJ/RI	67%	NM	14%
surgical patients who received appropriate timing of antibiotics to prevent infection								
CWF	51st 2005	-	50.0% 2005	-	CT	90.0%	NV	

HEALTH CARE QUALITY

	RANK		SCORE		STATE			
	*n*th	Δ	value	Δ	best		worst	
adult diabetics who received recommended preventive care								
CWF	46thm 2004	-	31.3% 2004	-	**HI**	65.4%	**MS**	28.7%
high-risk nursing home residents with pressure sores								
CWF	26th 2004	-	13.2% 2004	-	**ND**	7.6%	**DC**	19.3%
nursing home residents who were physically restrained								
CWF	45th 2004	-	11.3% 2004	-	**NE**	1.9%	**AR**	15.9%
long-stay nursing home residents admitted to a hospital								
CWF	20thn 2000	-	14.9% 2000	-	**UT**	8.3%	**LA**	24.9%
nursing home residents readmitted to a hospital within 3 months								
CWF	21sto 2000	-	11.0% 2000	-	**OR**	6.7%	**MS**	17.5%

MATERNAL & CHILD HEALTH

	RANK		SCORE		STATE			
	*n*th	Δ	value	Δ	best		worst	
mothers receiving late or no prenatal care								
CQP	39thp 2004	B 2001	7.3% 2004	B 2001	VT	1.5%	NM	
mothers receiving adequate prenatal care								
UHF	-q 2006	-	60.7% 2006	W 2003				
low-weight births [r/e]								
CQP	28th 2005	W 2001	8.3% 2005	W 2001	WA	6.1%	MS	11.8%
infantr mortality rate (per 1,000 live births) [r/e]								
UHF	13th 2005	B 2000	5.8 2005	B 2000	UT	4.4	MS	11.0
rate of legals abortions (per 1,000 woment) [r/e]								
KFF	43rdu 2005	W 2000	21 2005	W 2000	ID	4	NY	30
teenagev birth rate (per 1,000 women)								
CQP	40th 2005	W 2001	50.5 2005	B 2001	NH	18.0	NM	62.7
childrenw who have ever breastfed								
KFF	13th 2005	-	78.3% 2005	-	UT	90.3%	LA	47.9%
childrenx immunized								
UHF	50th 2007	W 2003	66.7% 2007	W 2003	NH	93.2%	NV	

MINORITY HEALTH DISPARITIES

	RANK		SCORE		STATE			
	*n*th	Δ	value	Δ	best		worst	
persons in poverty among Blacks								
KFF	7thy 2007	B 2001	27.8% 2007	W 2001	CT	20.6%	MS	43.6%
persons in poverty among Hispanics								
KFF	8thz 2007	B 2001	22.7% 2007	B 2001	HI	15.9%	MA	41.4%
non-elderly uninsured among Blacks								
KFF	11thaa 2007	B 2001	18.0% 2007	W 2001	DC	12.1%	LA	29.8%
non-elderly uninsured among Hispanics								
KFF	25thbb 2007	B 2001	34.9% 2007	B 2001	HI	13.1%	LA	56.7%
mothers beginning prenatal care in first trimester among Blacks								
KFF	33rdcc 2005	B 2002	62.5% 2005	B 2002	WY	88.5%	NY	48.9%
mothers beginning prenatal care in first trimester among Hispanics								
KFF	36thdd 2005	B 2002	58.4% 2005	B 2002	CA	83.8%	NY	50.9%
preterm births among Blacks								
	41stee 2006	W 2001	20.1 2006	W 2001	OR	11.4%	ID	23.3%
preterm births among Hispanics								
	40thff 2006	W 2001	13.5 2006	W 2001	MN	9.2%	MS	16.6
diabetes death rate among Blacks (per 100,000)								
KFF	1stgg 2005	N 2000	24.6 2005	W 2000	NV		NB	89.6
AIDS rate among Blacks (per 100,000)								
KFF	31st 2006	B 2002	48.8 2006	B 2002	ND	0.0	DC	277.5
AIDS rate among Hispanics (per 100,000)								
KFF	26th 2006	B 2002	16.1 2006	B 2002	MT/ND/SD /WV/WY	0.0	DC	109.2

HEALTH & WELL-BEING

MORTALITY

	RANK		*SCORE*		*STATE*			
	*n*th	Δ	value	Δ	best		worst	
age-adjusted death rate (per 100,000) [r/e]								
CQP	37thhh 2004	B 2000	877.9 2004	B 2000	HI	623.6	MS	998.2
years of life lost[ii] due to premature death (per 100,000)								
UHF	41st 2005	W 2003	8,610 2005	W 2003	MN	5,407	MS	11,308
death rate due to motor vehicle accidents (per 100,000)								
KFF	33rd 2005	-	19.3 2005	-	DC	6.9	MS	32.9
firearm death rate (per 100,000) [r/e]								
KFF	47th 2005	B 2000	16.3 2005	B 2000	HI	2.2	DC	23.8
occupational fatalities rate (per 100,000 workers[jj])								
UHF	3nd 2007	W 2003	6.7 2007	W 2003	MA	3.3	WY	14.3
age-adjusted death rate by suicide (per 100,000)								
CQP	48th 2003	B 2000	20.1 2003	B 2000	NY	5.9	WY	21.8
cardiovascular death rate (per 100,000)								
UHF	38th 2005	W 2007	320.3 2005	B 2003	MN	219.4	MS	387.0
heart disease death rate (per 100,000) [r/e]								
KFF	42nd 2005	W 2000	242.1 2005	B 2000	MN	141.5	MS	306.8%
age-adjusted death rate by malignant neoplasm (per 100,000)								
CQP	39th 2003	B 2000	202.6 2003	B 2000	UT	144.1	KY	223.6
cancer death rate (per 100,000) [r/e]								
CQP	18th 2007	B 2003	186.7 2007	B 2003	UT	105.5	WV	253.5
breast cancer death rate (per 100,000 women) [r/e]								
KFF	31st 2005	B 2003	24.0 2005	B 2003	AK	17.9	LA	29.9
colorectal cancer death rate (per 100,000)								
KFF	50th 2004	W 2003	21.4 2004	W 2003	UT	12.4	WV	22.2

MORBIDITY								
infectious disease rate (per 100,000)								
UHF	33rd 2007	B 2003	17.3 2007	B 2003	ND/WY	2.5	NY	39.3
STD rate (per 100,000)								
CQP	28th 2005	W 2001	441.7 2005	W 2001	NH	156.5	MS	981.3
AIDS rate (per 100,000) [r/e]								
CQP	37th 2005	B 2002	12.3 2005	B 2002	VT	1.0	NY	32.7
state and federal prison inmates infected with HIV								
KFF	27th 2006	W 2003	1.0% 2006	N 2003	ND	0.2%	NY	6.3%
adults who have ever been told they have diabetes [r/e]								
KFF	25th 2007		8.0% 2007		CO	5.3%	TN	11.9%
estimated rate of new cancer cases (per 100,000) [r/e]								
CQP	12th 2007	B 2003	442.0 2007	B 2003	ME	631.1	UT	300.4
hospital admissions for pediatric asthma (per 100,000 children)								
CWF	9thkk 2002	-	141.7 2002	-	VT	54.9	SC	314.2
BEHAVIOR								
motorists using safety belts								
CQP	3rdll 2005	B 2001	94.8% 2005	B 2001	HI	95.3%	MS	60.8%
adults who smoke [r/e]								
UHF	35th 2007	B 2003	21.5% 2007	B 2003	UT	11.7%	KY	28.2%
adults who binge drink								
CQP	45th 2005	W 2001	17.6% 2005	W 2001	UT	8.3%	WI	22.1%
adults who do not exercise								
CQP	36th 2005	W 2004	26.8% 2005	W 2004	MN	16.2%	LA	33.4%
adults who are obese [r/e]								
UHF	13th 2007	B 2003	24.6% 2007	W 2003	CO	19.3%	MS	32.6%

children[mm] who are overweight								
KFF	16th 2003	-	12% 2003	-	**UT**	9%	**DC**	23%
adults who had their teeth cleaned								
KFF	43rdnn 2004	**B** 1999	63.2% 2004	**B** 1999	**CT**	79.1%	**MS**	56.6%
WELL-BEING								
average poor physical health days (per month)								
UHF	36th 2007	**B** 2003	3.7 2007	**W** 2003	**ND**	2.7	**WV**	5.1
average poor mental health days (per month) [r/e]								
UHF	45th 2007	**B** 2003	3.8 2007	**B** 2003	**ND/SD**	2.4	**WV**	4.2
adults reporting poor mental health								
KFF	51st 2007	**N** 2003	38.5% 2007	**B** 2003	**LA**	23.4%	**NV**	
adults[oo] limited due to a physical, mental, or emotional issue								
CWF	18th 2004	-	21.2% 2004	-	**DC**	10.8%	**WV**	22.8%
high school graduation (of 9th graders)								
UHF	50th 2005	**W** 2003	55.8% 2005	**W** 2003	**NE**	87.8%	**NV**	
violent crime rate (per 100,000)								
UHF	48th 2007	**W** 2003	751 2007	**W** 2003	**ME**	118	**SC**	788
air pollution (per m^3)								
UHF	14th 2007	**B** 2003	9.6 µg 2007	**B** 2003	**AK**	7.6 µg	**GA**	15.9 µg

DEMOGRAPHICS*

	population 2008
Carson City	-
Carson City ☆	57,600
Churchill	26,981
Fallon ★	9,258
Clark	1,967,716
Enterprise	149,713
Henderson	269,538
Las Vegas ★	593,528
North Las Vegas	214,661
Paradise	182,264
Spring Valley	176,910
Sunrise Manor	185,745
Douglas	52,131
Gardnerville	5,412
Minden ★	3,261
Elko	50,561
Elko ★	18,424
Esmeralda	1,240
Goldfield ★	415
Eureka	1,553
Eureka ★	473
Humboldt	18,014
Winnemucca ★	7,659

	population 2008
Lander	5,891
Battle Mountain ★	2,922
Lincoln	4,352
Caliente	1,077
Pioche ★	785
Lyon	55,820
Fernley	19,609
Yerington ★	3,324
Mineral	4,401
Hawthorne ★	2,970
Nye	47,370
Pahrump	38,882
Tonopah ★	2,628
Pershing	7,192
Lovelock ★	2,458
Storey	4,384
Virginia City ★	1,027
Washoe	423,833
Reno ★	223,012
Sparks	91,684
White Pine	9,694
Ely ★	4,352
Nevada	**2,783,733**

DEMOGRAPHICS

	population 2005	percent 2005
0 to 5 years	34,633	1.38
6 to 18 years	454,285	18.07
19 to 64 years	1,563,853	62.22
65 years and older	280,885	11.18
males	1,276,344	50.78
females	1,237,085	49.22
White	1,561,549	62.13
Black	172,945	6.88
American Indian, Eskimo, or Aleut	33,552	1.33
Asian or Pacific Islander	159,416	6.34
Hispanic	585,966	23.31

ENDNOTES

[a] less than 18 years old, unless otherwise specified
[b] of 50 states not including DC
[c] age 18 to 64
[d] of 44 states and DC
[e] non-federal short-term general and other special hospitals, including those in hospitals and nursing home units
[f] the difference between counties having the highest and lowest mortality rates
[g] at least one person thought of as a one's personal doctor or health care provider
[h] having at least one preventive medical care visit in the past year, access to specialist care and services, and a personal doctor or nurse
[i] age 50 and older
[j] age 1 to 17
[k] cases considered partially treatable or preventable with timely and appropriate medical care
[l] cases for which appropriate and timely treatment by a primary health care provider would have avoided hospitalization
[m] of 47 states
[n] of 48 states
[o] of 48 states
[p] of 41 states
[q] unrankable due to old and new birth certification standards; Nevada ranked 10% below its respective peer group of states using the same standard.
[r] less than 1 year old
[s] For further information, see the methods section of the Morbidity and Mortality Weekly Report, v 57, n SS-13.
[t] age 15 to 44
[u] of 46 states and DC
[v] age 15 to 19
[w] born in 2005
[x] age 19 to 35 months
[y] of 36 states and DC
[z] of 41 states and DC
[aa] of 32 states and DC
[bb] of 45 states and DC
[cc] of 38 states and DC
[dd] of 38 states and DC
[ee] of 47 states and DC
[ff] of 50 states and DC
[gg] of 39 states and DC
[hh] of 47 states
[ii] the number of years of potential life lost prior to age 75
[jj] number of fatalities for KFF
[kk] of 33 states
[ll] of 48 states
[mm] age 10 to 17
[nn] of 49 states and DC
[oo] less than 65 years old
[*] estimates provided by SND

STATE OF NEVADA

JIM GIBBONS
Governor

MICHAEL J. WILLDEN
Director

RICHARD WHITLEY, MS
Administrator

MARY GUINAN, MD, PhD
State Health Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH DIVISION
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Recognizing the Components of Nevada's Health Care System: In Response to the Hepatitis C Outbreak

A Necessary Step for Ensuring Patient Safety with Regard to Infection Control

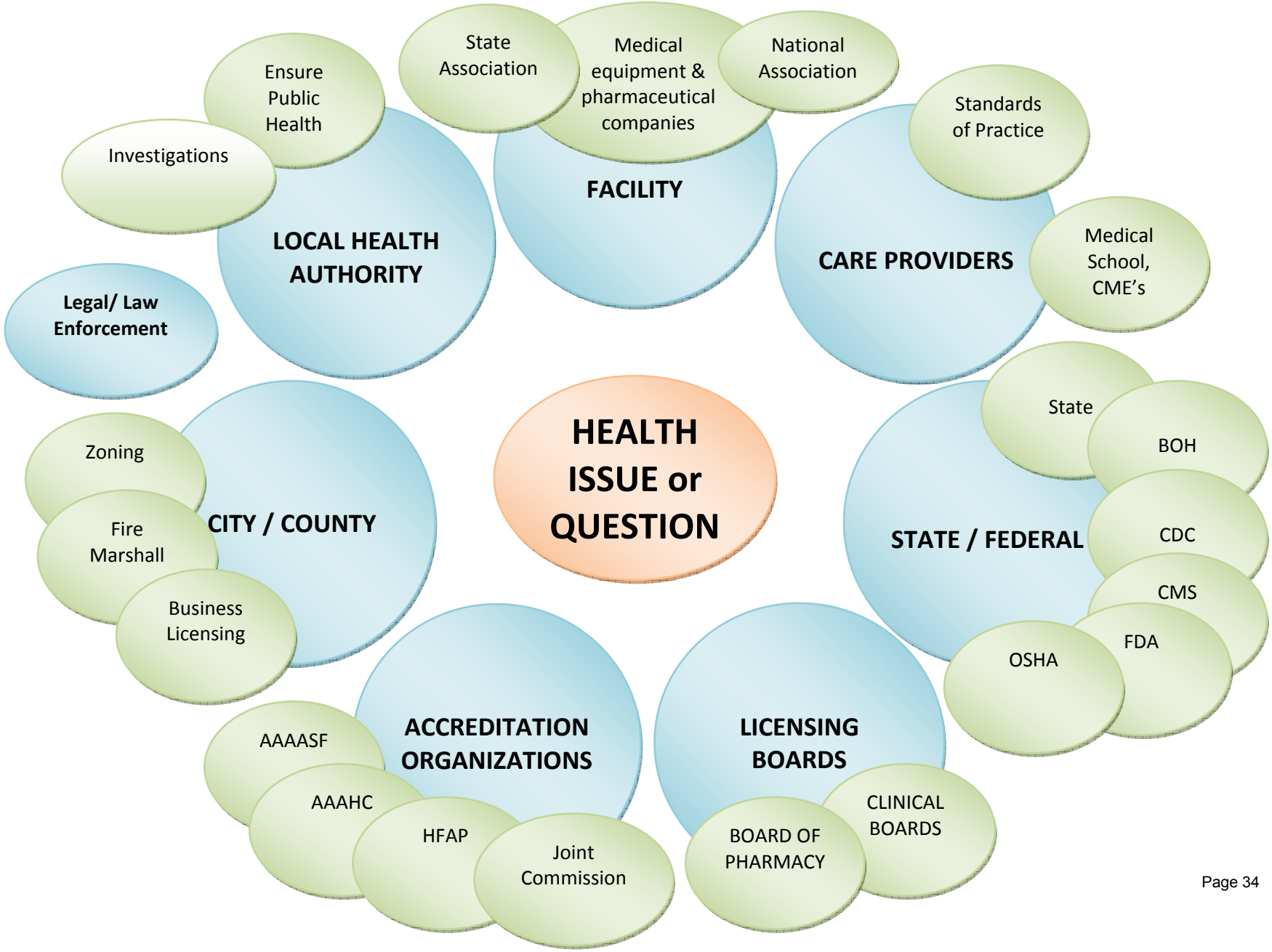
Mary Guinan, MD, PhD, State Health Officer

In 2005 report from the Institute of Medicine of the National Academy of Sciences entitled "To Err is Human" the expert committee outlined how medical errors occurred in health care settings. The authors point out that health care is a system which includes a vast network of health care professionals. Medical errors were often attributed to a "systems failure", i.e., some part of the network failed. In order to correct medical errors then they suggested a systems approach to prevention of medical errors. The great barrier to this is that the US health care system is too complex to understand who is responsible for what and that no clear lines of accountability existed. Therefore the authors suggested that what we have in the United States is a "non system of health care".

In 2008 in Las Vegas NV, Southern Nevada Health District revealed a Hepatitis C outbreak in Las Vegas linked to endoscopy centers. Federal, state and local public health investigators linked the outbreak to unsafe injection practices. Further investigation showed that the problem was clearly a "systems problem" for the Health Care/Public Health system in Nevada with failures at multiple levels. Therefore Nevada needed a "systems" approach to prevention. How can we ensure that this never happens again in Nevada? The Health Division started to examine all of the agencies and individuals in Nevada that were part of this system and what went right and what went wrong that resulted in the Hepatitis C outbreak. The State has primacy in matters of health and the State is responsible for understanding what the system is. The Health Division created what was called a **"bubble chart"** to identify all the agencies and individuals and their interactions and where the system failed to protect the patient and where were the lines of accountability. No other state to our knowledge has identified the components of their complex health system. This is the first "bubble chart" in attachment which is entitled "Recognizing the Components of Nevada's Health Care System: In Response to the Hepatitis C Outbreak". The following "bubble chart" is the "Systems Response to Prevent Blood Borne Infections in Medical Facilities". The following pages show a listing of the various issues that arose during the Hepatitis C Investigation and the approach to solving the problems.

As this "systems" approach was further studied it became clear that the framework of the system was solid but the components of the system may vary slightly depending on the problem being addressed.

TEMPLATE


State Association
Medical equipment & pharmaceutical companies
National Association
Ensure Public Health
Investigations
LOCAL HEALTH AUTHORITY
FACILITY
Standards of Practice
CARE PROVIDERS
Medical School, CME's
Legal/ Law Enforcement
HEALTH ISSUE or QUESTION
Zoning
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CITY / COUNTY
State
BOH
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